The Commonwealth of Massachusetts
Division of Professional Licensure
Board of Allied Mental Health and Human Services Professions
239 Causeway Street
Boston, MA 02114

APPLICATION INFORMATION FOR LICENSURE AS A MENTAL HEALTH COUNSELOR

Prior to completing the application, it is strongly recommended that all applicants obtain a copy of 262 CMR from the State Bookstore, Room 116, State House, Boston, MA 02133, (617) 727-2834, or online <http://www.mass.gov/reg/boards/mh> and verify that all educational, exam, and supervision requirements are met. It is also recommended that applicants maintain a copy of their application for their records.

All applicants must pass the National Clinical Mental Health Examination (NCMHCE) in order to become licensed. Enclosed with this application are necessary registration materials to sit for the exam. If you have already passed the exam, submit an official score report with your application.

There is a non-refundable application fee of $102, which must be in the form of a check or money order payable to the Commonwealth of Massachusetts. All fees must accompany the completed application.

Prior to submitting an application, please make sure the following information is included:

1. A completed application form including a notarized signature (pp. 2-6);
2. A completed Post-Master's Clinical Field Experience form (7-8);
3. A completed Internship Clinical Field Experience form (9-10);
4. A completed Practicum Clinical Field Experience form (11-12);
5. Proof of passing the NCMHCE (if you have already taken the exam);
6. Official transcript of a qualifying master's degree; and
7. A check or money order in the amount of $102, payable to the Commonwealth of Massachusetts.

Please do not include the following:

1. Undergraduate transcripts;
2. Letters of reference;
3. Continuing Education Certificates

All application materials should be submitted to:

Board of Allied Mental Health and Human Services Professions
239 Causeway Street
Boston, MA 02114

Should you have any questions about the application process, please contact the Board at 617-727-3080 or via email <susan.e.coco@state.ma.us>

The Commonwealth of Massachusetts
Division of Professional Licensure
Board of Allied Mental Health and Human Services Professions
239 Causeway Street
Boston, MA 02114

Please attach recent

2" x 2"

head and shoulder photograph

MENTAL HEALTH COUNSELOR LICENSURE APPLICATION
NON-REFUNDABLE APPLICATION FEE: $102.00

1. Name: _____
Last First Middle Maiden

2. Residence: _____
No. Street Apt. No.

_____
City/Town State Zip Code

3. Business: _____
Company Name

_____
Street .

_____
City/Town State Zip Code

4. Date of Birth: _____ Social Security Number _____-_____-_____

5. Telephone No: Day _____Evening _____

6. Email:_____

7. Pursuant to G.L c. 62, s. 49A, I have filed all state tax returns and paid all state taxes required under law: ☐ Yes ☐ No If no, please explain _____
_____

If you have ever held a license in another state, please complete the information below.				
State	**License Number**	**Issue Date**	**Current**	**Lapsed**
A letter of standing from each state listed must be sent to the Board separately.				

DISCIPLINARY HISTORY

If you answer "Yes" to any of the following questions, please attach a full explanation.

A. Has any disciplinary action been taken against you by a licensing/certification board located in the United States or any country or foreign jurisdiction? Yes __ No __

B. Are you the subject of pending disciplinary action by a licensing/certification board located in the United States or any country or foreign jurisdiction? Yes __ No __

C. Have you voluntarily surrendered or resigned a professional license to a licensing/certification board located in the United States or any country or foreign jurisdiction? Yes __ No __

D. Have you ever applied for and been denied a professional license in the United States or any country or foreign jurisdiction? Yes ___ No ___

E. Have you ever been convicted of a felony or misdemeanor in the United States or any country or foreign jurisdiction, other than a traffic violation for which a fine of less than $200 was assessed? Yes ___ No ___

EDUCATION				
College or University	**Degree**	**Year**	**Major**	**Credits**
A. Masters				
B. Post-Master's Credits (non-CAGS)				
C. Second Master's Degree				
D. CAGS or other post-master's certificate				
E. Doctoral Degree				
Official transcripts must be provided from all graduate institutions.				

CERTIFICATION/MEMBERSHIP STATUS

Do you have a current certification as a Certified Clinical Mental Health Counselor (CCMHC) through the National Board of Certified Counselors (NBCC)? ☐ No ☐ Yes
(If yes, attach an official notification from the NBCC of professional CCMHC standing)
(If no, please continue with the rest of the application)

Please list the date you passed the National Clinical Mental Health Counseling Examination (NCMHCE)

_____

SUPERVISED CLINICAL EXPERIENCE

Practicum Pre-Master's Degree Clinical Experience

Dates of Clinical Experience: From _____ to _____

Name and Address of Facility _____

_____

Your Title _____

Name of Supervisor_____ Supervisor's Title _____

Internship Pre-Master's Degree Clinical Experience

Dates of Clinical Experience: From _____ to _____

Name and Address of Facility _____

_____

Your Title_____

Name of Supervisor _____ Supervisor's Title _____

Post-Master's Degree Clinical Experience

Dates of Clinical Experience: From _____ to _____

Name and Address of Facility _____

_____

Your Title _____

Name of Supervisor _____ Supervisor's Title _____

Pursuant to G.L. c. 119 s. 51A and G.L. c. 112, s. 1A, my signature on this application is my certification that I understand my obligation to report the abuse or neglect of children.

AFFIDAVIT: The applicant named on this application agrees to abide by the rules and regulations for the licensing of Mental Health Counselors and attests that all statements are truthful and are made under the pains and penalties of perjury.

SIGN IN THE PRESENCE OF A NOTARY PUBLIC

_____ _____

Signature of Applicant *Date*

_____ _____

Signature of Notary Public *Date*

_____ _____

Printed Notary Name *Date Commission Expires*

COURSEWORK REQUIREMENTS FORM
(For applicants who completed their degrees PRIOR to July 1, 1998)

REQUIRED COURSES

Must have all three courses. Each course taken can only be used to fill one requirement.

Course Content Area	Corresponding Course Number on Transcript
Counseling Theory, Practice and Techniques	
Human Psychology, Development, Behavior and learning, and Personality Theory	
Psychopathology, Abnormal Psychology, Abnormal Behavior, Etiology, Dynamics, and Treatment of Abnormal Behavior	

ELECTIVE COURSES

Must have six (6) of the following courses. Each course taken can only be used to fill one requirement.

Course Content Area	Corresponding Course Number on Transcript
Social and Cultural Foundations, Populations and Cultures	
Group Dynamics and Development	
Appraisal/Assessment/Crisis Intervention/DSMIIIR	
Research and Evaluation	
Professional Orientation Ethics/Legal Issues	
Psychopharmacology for Non-Medical Professions	
Addiction Disorders	
Marriage and Family/Human Sexuality and Lifestyle Choices	
Psychotherapeutic Techniques, Treatments and Modalities	
School Counseling/Career and Lifestyle Choices	

COURSEWORK REQUIREMENTS FORM
(For applicants who completed their degrees AFTER July 1, 1998)

Please review your transcript and specify the course number which corresponds to the course content area listed below.

REQUIRED COURSE AREAS

A minimum three-semester hour or four-quarter hour course must be taken in each of the ten areas. Each course can be used to fill only one requirement.

Course Content Area	Course Number on Transcript
Counseling Theory: theories of psychotherapy and counseling, theories of personality, treatment and prevention modalities	
Human Growth and Development: understanding the nature of human development	
Psychopathology: identification, diagnosis of and treatment planning for abnormal, deviant or psychopathological behavior	
Social and Cultural Foundations: issues and trends of a multicultural and diverse society	
Helping Relationships: counseling techniques, skills and procedures	
Group work: dynamics and processes	
Special Treatment Issues *	
Professional Orientation: ethical and legal issues in counseling	
Appraisal: psychological assessment and techniques	
Research and Evaluation	

* Special Treatment Issues: e.g. psychopharmacology, substance abuse, school and career issues, marriage and family treatment, sexuality and lifestyle choices, treating special populations.

ELECTIVE AREAS

Elective courses must include knowledge and skills in the practice of mental health counseling. Students should understand the scope of practice and learn the responsibilities in the clinical practice of mental health counseling.

Appropriate courses could include any of the special treatment issues listed above, as well as modalities for maintaining and terminating counseling and psychotherapy, psychopharmacology, consultation skills, outreach and prevention strategies, diagnosis and treatment issues, historical perspectives and multiple dimensions of mental health counseling, professional identity and practice issues, mental health regulations and policy, management of community programs. Similar related courses are also appropriate.

NAME: _____

POST-MASTER'S CLINICAL FIELD EXPERIENCE

List relevant mental health counseling experience. Photocopy as necessary.

1. Name/ Address of Facility **2. Signature of Supervisor**	**Dates of Supervision**	**Hours of Experience**	**Hours of Clinical Experience**	**Individual Supervision (by this Supervisor)**	**Group Supervision (by this Supervisor)**
1. 2.	From: To:	a) Hrs/Week _____ b) # of Weeks _____ Total (a x b): _____	a) Hrs/Week _____ b) # of Weeks _____ Total (a x b): Group_____ Individual _____	Hrs/Week _____ # of Weeks _____ Total (a x b): _____	Hrs/Week _____ # of Weeks _____ Total (a x b):_____
Minimum-		**3,360**	**960 (250 max. may be group)**	**75 Minimum** **{Minimum total of 130 hours}**	**No Minimum**

Has disciplinary action ever been taken against you within the last ten years by any of the following:	**Yes**	**No**
Governmental authority (e.g. state licensing Board)	☐	☐
Third Party Insurance Carrier	☐	☐
Professional Association or Organization	☐	☐
I have 5 years of clinical mental health counseling experience	☐	☐

The undersigned states, under the pains and penalties of perjury, that the above statements and the statements on the reverse side of this page are true and correct and that the undersigned is not a relative of the applicant.

_____ _____

Signature of Approved Supervisor *Date*

~ Turn Over ~

Approved Supervisor. An approved supervisor is a mental health practitioner who meets the qualifications listed under subcategory (a), (b), (c), (d), or (e); all of these approved supervisors must have five (5) years of full time or the equivalent part time postgraduate clinical mental health counseling experience.

(a) LMHC; a currently licensed mental health counselor.

(b) A CCMHC; a Certified Clinical Mental Health Counselor who holds a currently valid certificate.

(c) a licensed mental health practitioner who:
1. has a master's degree in social work and is licensed for independent clinical practice;
2. has a master's degree in marriage and family therapy;
3. has a doctoral degree in clinical, counseling or developmental psychology or a medical degree with a sub-specialization in psychiatry.

(d) A licensed mental health practitioner who has:
1. a master's or doctoral degree in rehabilitation counseling, pastoral counseling, psychiatric nursing, developmental or educational psychology, or related fields;
2. successfully completed a Supervised Clinical Experience; and
3. achieved a passing score on the NCMHCE licensure examination.

(e) An out of state supervisor who is a licensed mental health practitioner (in states that have licensure in their discipline) and who meets the qualifications for licensure for independent clinical practice in Massachusetts in his/her respective discipline.

MASSACHUSETTS SUPERVISOR: Please list which of the above describes your license.

_____ ***LICENSE/CERTIFICATE #*** _____

OUT OF STATE SUPERVISOR: Please attest that you meet the qualifications for individual clinical practice in Massachusetts by your signature below.

License # _____ State_____ Credential _____

NAME: _____

PRE-MASTER'S **INTERNSHIP** CLINICAL FIELD EXPERIENCE

List relevant mental health counseling experience. Photocopy as necessary.

1. Name/ Address of Facility 2. Signature of Supervisor	Dates of Supervision	Hours of Experience	Hours of Clinical Experience	Individual Supervision (by this Supervisor)	Group Supervision (by this Supervisor)
1. 2.	From: To:	Hrs/Week _____ # of Weeks _____ (a x b) _____	a) Hrs/Week _____ b) # of Weeks _____ (a x b) _____	Hrs/Week_____ # of Weeks _____ (a x b) _____	Hrs/Week_____ # of Weeks _____ (a x b) _____
Minimum-		**600**	**240**	**15 Minimum** **{Minimum total of 45 hours}**	**15 Minimum**

Has disciplinary action ever been taken against you within the last ten years by any of the following:	**Yes**	**No**
Governmental authority (e.g. state licensing Board)	☐	☐
Third Party Insurance Carrier	☐	☐
Professional Association or Organization	☐	☐
I meet the requirements of (f) on the reverse side of this page	☐	☐

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1. a master's or doctoral degree in rehabilitation counseling, pastoral counseling, psychiatric nursing, developmental or educational psychology, or related fields;
2. successfully completed a Supervised Clinical Experience; and
3. achieved a passing score on the NCMHCE licensure examination.

(e) An out of state supervisor who is a licensed mental health practitioner (in states that have licensure in their discipline) and who meets the qualifications for licensure for independent clinical practice in Massachusetts in his/her respective discipline.

(f) For the specific purpose of the college supervision (e.g. support seminars) of students in a practicum or internship, an approved supervisor may be a mental health practitioner who:
1. holds a teaching or supervisory position in an educational institution which trains mental health counselors; and
2. holds a graduate degree in mental health counseling or a related field.

Site supervisors for practica and internships must meet the qualifications for Approved Supervisor (a), (b), (c), (d), or (e).

MASSACHUSETTS SUPERVISOR: Please list which of the above describes your license.

_____ ***LICENSE/CERTIFICATE #*** _____

OUT OF STATE SUPERVISOR: Please attest that you meet the qualifications for individual clinical practice in Massachusetts by your signature below.

License # _____ State_____ Credential _____

NAME: _____

PRE-MASTER'S **PRACTICUM** CLINICAL WORK EXPERIENCE

List relevant mental health counseling experience. Photocopy as necessary.

1. Name/ Address of Facility 2. Signature of Supervisor	Dates of Supervision	Hours of Experience	Hours of Clinical Experience	Individual Supervision (by this Supervisor	Group Supervision (by this Supervisor
1. 2.	From: To:	a) Hrs/Week _____ b) # of Weeks _____ (a x b) _____	a) Hrs/Week _____ b) # of Weeks _____ (a x b) _____	Hrs/Week_____ # of Weeks _____ (a x b) _____	Hrs/Week_____ # of Weeks _____ (a x b) _____
Minimum-		**100**	**40**	**10 Minimum**	**5 Minimum**

{Minimum total of 25 hours}

Has disciplinary action ever been taken against you within the last ten years by any of the following:	**Yes**	**No**
Governmental authority (e.g. state licensing Board)	☐	☐
Third Party Insurance Carrier	☐	☐
Professional Association or Organization	☐	☐
I meet the requirements of (f) on the reverse side of this form	☐	☐

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(b) LMHC; a currently licensed mental health counselor.

(b) A CCMHC; a Certified Clinical Mental Health Counselor who holds a currently valid certificate.

(c) a licensed mental health practitioner who:

1. has a master's degree in social work and is licensed for independent clinical practice;
2. has a master's degree in marriage and family therapy;
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License # _____ State_____ Credential _____